Addendum II to OPL #59

June 23,
1998

NOTE TO: All Medicare Contracting HMOs and CMPs

SUBJECT: Addendum II to Operational Policy Letter #59

This note transmits the second addendum to OPL #59, *Reporting Requirements for Medicare Health Plans in 1998: HEDIS® 3.0/98 Measures and the Medicare Consumer Assessment of Health Plans Study (CAHPS).* This addendum provides further elaboration on the 1998 HEDIS audit and the release of HEDIS performance information, as well as updates on the CAHPS and Health of Seniors surveys.

We will soon provide clinical and service information to beneficiaries, and to share information with health plans for their use in quality improvement activities. Thus, the importance of having accurate and reliable data is critical. We appreciate the efforts of health plans in this major activity which will move the managed care industry forward in providing high quality health care.

It is critical that your health plan staff involved in implementation of the HEDIS measures and the surveys receive this information as soon as possible.

/s/

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ADDENDUM II TO OPL #59
Reporting Requirements for Medicare Health Plans
HEDIS® 3.0/98 and the Medicare CAHPS

Addendum II to Operational Policy Letter (OPL) #59, dated December 27, 1997, discusses several issues related to the HEDIS reporting requirements for 1998. Specifically, it addresses certain aspects of the HCFA-sponsored audit; the submission of HEDIS data; the release of HEDIS performance information; and an update of the CAHPS and Health of Seniors (HOS) surveys.

[Reference: Addendum I to OPL #59, dated March 20, provides additional information on HEDIS reporting: the mandatory audit of all contracts prior to submission of the

summary data, and related change in submission dates; changes to and clarifications to reporting requirements for cost health plans; and updates on the HOS and CAHPS surveys.]

I. AUDIT ISSUES

The 1997 audit of HEDIS data for services provided in 1996 indicated several areas impacting on performance measurement which needed further study. The audit included on-site visits to a sample of Medicare contracts for an in-depth assessment of health plan information systems used in producing HEDIS data. The review looked at systems related to medical data (forms, coding, and data transfer and entry), membership data, provider data and data integration and control procedures. Based on the findings of last year's audit activity, HCFA determined that several additional audit elements were necessary in order to release health plan performance information with some reliability.

Therefore, the audit of 1997 data (being reported in 1998) includes several elements which will remedy limitations in the first Medicare HEDIS audit. These are:

A. The audit is being conducted prior to submission of the data to allow plans an opportunity to correct errors resulting in more accurate rates, where possible.
B. Medical record reabstraction is being conducted to assess the validity of medical record abstractions for collecting data by the hybrid method.
C. Completeness of health plan databases is being assessed for its impact on reporting measures (see below).

COMPLETENESS EVALUATION STUDY

Completeness of the databases is a critical factor in how reliable performance measurement is, both for publication of information and quality improvement purposes. The 1997 Medicare HEDIS audit identified, for those audited, that approximately 25 percent of the reporting units developed rates for utilization measures that were based on substantially incomplete databases.

Related to clinical performance measurement, completeness is the percentage of services actually provided that are documented in the claims/encounter databases available to the health plan at the time of HEDIS reporting. Data completeness is affected by two key issues:

D. Lag factors (i.e., timeliness of provider claims/encounter submissions); and
E. Requirements for claims/encounters (e.g. the extent to which providers, especially those paid under capitated arrangements, are contractually required to submit claims/encounters to document the services that they

provide, and the extent to which the MCO provides oversight; incentives for submitting data).

Related to the databases for provider membership data, completeness addresses how current the information is and how multiple provider and membership databases are integrated and data transferable.

As part of the current audit, the auditors will assess several areas for completeness. However, in determining whether a given rate will receive a "Report" or "Not Report" designation for submission and eventually for publication, the assessment of completeness will NOT be used.

The areas which will be assessed for completeness are:

F. Medical data (primary care, specialty, inpatient), provider data, and membership data; and
G. The databases used to prepare each of the measures being audited, to estimate the extent of under-reporting;

The auditors will document their assessments and, to the extent possible, estimate the impact of incompleteness on the rates. HCFA has identified ranges for completeness and the auditors will score each contract market in its report.

Although HCFA will not use completeness scores for plan-to-plan comparison this year (1997 service data), it will assess the distribution of the completeness impact from the scores assigned by the auditors. HCFA expects that in 1999, for reporting services provided in 1998, completeness will be a factor in determining the Report or Not Report designation for each measure. At a minimum, we expect that health plans will take actions necessary to improve the completeness of their databases and systems used in developing their HEDIS, other performance measurements, and quality improvement activities.

MEDICAL RECORD REVIEW

In mid-May, HCFA's contractor for its audit program, Island Peer Review Organization (IPRO), sent information to MCOs reporting HEDIS data under OPL #59. This material related to the medical record review validation for measure rates which were developed through the hybrid method. IPRO, which is doing all of the medical record review, will provide auditors with detailed information on the accuracy of medical record review. The results of the review will be a factor in determining whether the rate will be reportable or will receive a Not Report.

MANDATORY FIELDS FOR EFFECTIVENESS OF CARE MEASURES

HCFA requires that all fields on the screen for each Effectiveness of Care (EoC) measure be completed. The auditors will verify this and complete a table, which includes all the fields, as part of their report.

II. DATA SUBMISSION

HOW TO SUBMIT HEDIS MEASURES

Plans will report the audited rates in accordance with the auditor designations, as agreed upon between the plan and auditor. These are discussed below. Please note that these statements are consistent with the data submission tool (DST) and the User's Guide issued by the National Committee for Quality Assurance (NCQA) in May.

"Report" designation means:

A. Less than 5 percentage point difference in the reported rate from full adherence to the specifications for EoC, access, provider turnover and board certification/residency completion measures.
B. Less than 10 percent change in the number of numerator events (i.e., number of procedures) for the Frequency of Selected Procedures measure.

The audit report will identify whether the "Report" designation is "RF" for fully compliant or "RS" for substantially compliant. However, MCOs will only submit numeric values (agreed upon with auditors) for the numerators and denominators for those measures for which they receive this designation; the rates will be automatically calculated by the DST.

"Not Report" (NR) designation means:

C. 5 or more percentage point difference in the reported rate from full adherence to the specifications for EoC, access, provider turnover and board certification/residency completion measures.
D. 10 or more percent change in the number of numerator events (i.e., number of procedures) for the Frequency of Selected Procedures measure.

MCOs will submit "NR" for all measures which receive "Not Report" designation by the auditor. The numerator/denominator numbers should not be reported on the DST for these measures; they should be left blank. "NR," as the default setting, will appear.

Note to Cost Plans:

Cost plans, which are not required to report certain inpatient measures (see OPL #59 Addendum I, Attachment I; and Data Submission Tool, User's Guide, Summary of Medicare Only Requirements, item 2), will automatically report the

DST's default response, a "NR," for these measures. However, this "NR" is meaningless because these measures are not required. HCFA will not consider any cost plan responses to inpatient measures.

"Not Applicable" designation means:

E. There is an inadequate number of members who meet the HEDIS specifications for a given measure. One reason would be that the plan has a small Medicare population. However, for this type situation, the numerator and denominator must be provided. The DST will automatically calculate a rate which the MCO may not override. However, NCQA will change this to NA.

F. Any measure involving continuous enrollment specifications for which the MCO had no members that met these specifications. For example, the MCO's contract might be in effect for less than the continuous enrollment period, and the MCO had no "age-ins" (i.e., MCO members, who upon turning age 65, enroll through the Medicare risk or cost contract) who met these specifications.

G. Any measure for which HEDIS specifies that reporting is not required if the benefit is not offered by the MCO (e.g., outpatient drug benefit). There would be a zero for the numerator and denominator.

The reports provided to MCOs by auditors will indicate when NA is the appropriate designation. However, in entering data on the DST, MCOs will not be able to enter NA. For the situations enumerated above, the DST will automatically calculate a rate or default to an NR. As part of its edit activity, NCQA will change these fields to the appropriate NA prior to sending the data to HCFA.

THE DATA SUBMISSION TOOL

HCFA requires that the Medicare DST not permit override capability of automatic calculations. This is a major difference from the one for commercial insurers and Medicaid. In those situations when a rate is automatically calculated but the cell should reflect NA (e.g., when the denominator size is less than 30), NCQA will appropriately change the rate to the NA designation prior to sending the data to HCFA.

Should an MCO wish to explain why it believes an override would be necessary, it should forward this explanation via e-mail to HCFA at HEDISsub@hcfa.gov.

III. AUDIT INFORMATION RELEASE BY HCFA

Patient level and proprietary information will not be released, consistent with the Privacy Act and the Freedom of Information Act.

For 1997 service data, there will be at least two releases of audit information on each contract market for each audited measure. These are identified below, along with the type of information HCFA expects, at this time, to release.

1. For beneficiaries:

   As part of the annual beneficiary information campaign to assist beneficiaries in making health care choices:

   - Numeric rates, NR and NA; and
   - Notation if completeness level would have major impact on rate.

2. For the general public, researchers, other interested parties:

   In addition to the above information which would be in the public domain, the following is being considered for release:

   If a rate is reported:

   - whether based on full (100%) compliance or substantial (95-99%) compliance;
   - numerator/denominator; and
   - completeness impact.

   If NR is reported:

   - Reason for NR designation (e.g., Problems with coding, incorrect sampling methodology, systems);
   - completeness impact (by range to differentiate low from almost at report level); and
   - completeness assessment on the information systems (medical, provider, enrollment, integration).

CAHPS SURVEY

1997 CAHPS Survey (1997 Reporting Requirements)

HCFA finished data collection for the 1997 CAHPS Survey in May, which included all section 1876 risk and cost health plans whose Medicare contracts were in effect on or before January 1, 1996. In the beginning of September, plans included in the 1997 CAHPS Survey will have an opportunity to review their plan information that will be available to beneficiaries in November. HCFA will provide each plan with detailed instructions regarding this review process.

In November, HCFA will release plan-specific information from the CAHPS Survey on Medicare Compare, a tool on HCFA's Web site that

contains comparative information on managed care plans. The CAHPS information will be presented along with other plan specific information such as costs, provider choice, and benefits. For this year, Medicare beneficiaries will be able to access the HCFA Web site to obtain CAHPS information or to request a hard copy of this information through HCFA's 1-800 number or our regional offices. In future years, CAHPS information will be sent to beneficiaries as part of an annual mailing.

This Fall, each plan included in the 1997 Survey will also receive a more extensive report which will include a full description of the survey methodology and summary information on multiple measures from the survey. From this report, plans will be able to see how they perform on various dimensions relative to other plans in their area and the nation. This information is intended to be used by plans for their internal quality improvement activities. Person-level data from the survey is protected by the Privacy Act and, consequently, will not be provided to the plans.

1998 CAHPS Survey (1998 Reporting Requirements)

The 1998 CAHPS Survey will begin in September. All section 1876 risk and cost health plans whose Medicare contracts were in effect on or before January 1, 1997 will be included in this survey. The CAHPS Survey is primarily a mail survey with telephone follow up of nonrespondents. In August, HCFA's contractor for the survey, Westat, will send each plan a diskette which includes a file with a list of its Medicare beneficiaries, some of whom will be surveyed. HCFA will ask the plans to provide telephone numbers for each beneficiary listed on the diskette.

V. HOS SURVEY

Baseline data collection for cohort one of the HOS survey began on May 26. Approximately 279,000 beneficiaries, from 268 MCOs covering 287 market areas, received surveys. Initial data collection should be completed in July. This first cohort will be resurveyed in the Spring of 2000. While financial and time constraints limited our first administration to an English language version, we have undertaken three special initiatives:

7. We are working collaboratively with the Chinese Community Health Plan in San Francisco in administering to their Medicare enrollees the Chinese language version of the same health status measurement tool utilized in the HOS survey;
8. We are collaborating with the New England Research Institutes, the Health Assessment Laboratory at Tufts University, and the NCQA in the development of a Spanish language version of the entire HOS Survey; and,

9. We are collecting information from the initial HOS data collection effort which will allow us to ascertain which additional languages/special populations might require development of alternative HOS translations.

While individual patient-level data will not be provided to plans after baseline data collection, you will receive two types of aggregate reports for Year 1.

Vendors administering the survey have been directed to issue to contracted plans three reports that provide indicators on the progress of mail and telephone survey administration. Each report will consist of a table containing data on the number of surveys issued during the first and second survey mailings, the number of surveys returned completed or partially completed, the number of sampled members for whom a survey could not be obtained (e.g., due to death, disenrollment, language barrier), and mail and telephone response rate calculations. Plans should expect to receive reports on or about June 21, July 14, and August 11. The June and July reports will not contain information on telephone administration (the telephone interviewing phase of the protocol begins July 10). The August report will contain final mail and telephone response rates.

Aggregate health status data from the baseline collection will be returned to the plan as part of an integrated education strategy within which HCFA will provide training to all participating MCOs and Peer Review Organizations (PROs). These sessions will link the results of an information synthesis on the state-of-the-art in interventions which improve functional status with a plan-specific aggregate risk profile constructed from Year 1 data. MCOs and PROs will learn how to use the results of the information synthesis and risk profiling to improve the quality of care provided to beneficiaries in MCOs.

The training session for MCOs will be held in Boston in early November. All plans participating in round one of the HOS survey are strongly encouraged to attend. More information will be available in the near future from HCFA's contractor, Health Services Advisory Group.

Plans may visit the NCQA web site to obtain information on key dates in the HOS survey protocol. From the NCQA home page, click on "Healthcare Organizations" and click on "Information for Medicare plans and HOS vendors" under the "Other NCQA Resources" heading.

3. MISCELLANEOUS

COST PLANS:

Cost plans should be alert to an error in Attachment I to Addendum I of OPL #59. Page 4 states that section 1876 cost plans will not report the Use of Services inpatient measures. However, on Attachment I which lists measures which cost plans must report, Frequency of Selected Procedures was inadvertently included. This measure will not be included in the audit, and will not be reported by cost plans.

RESOURCES:

For questions regarding specifics in this OPL, please contact the following people or e-mail addressees. For all communications, please note contract number and market area.

0. General policy questions:
    - Richard Malsbary, Center for Health Plans and Providers, 410-786-1132
    - Connie Forster, Office of Clinical Standards and Quality, 410-786-1036.
1. Technical audit questions:
    - Herman Jenich, IPRO, 516-326-7767, ext. 314.
2. DST related questions:
    - NCQA, as directed in the DST User's Guide and other supporting materials.
3. CAHPS:

    Liz Goldstein, Center for Beneficiary Services, 410-786-6665; or e-mail to CAHPS_Survey@hcfa.gov

4. HOS:
    - Chris Haffer, Office of Clinical Standards and Quality, 410-786-8764 or e-mail health_of_seniors@hcfa.gov regarding policy issues, special initiatives, and data dissemination.

Kris Spector, NCQA, 202-955-1749 regarding operational issues.